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PROBLEM MOTHERS AT A CHILD GUIDANCE CLINIC

A Thesis

Submitted by

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(Ph.D., University of Vienna, 1923)

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CHAPTER I

INTRODUCTION

The cases used in this study are mothers who brought their children to the West End Child Guidance Clinic, September 1941 - May 1942. The Clinic is sponsored by the State Department of Mental Health, Division of Mental Hygiene, Massachusetts.

The personnel consists of a psychiatrist, a psychologist and three social workers. The psychiatrist as well as the social workers see mother and child and work with them. The treatment is directed by the psychiatrist and the social workers assist in carrying it out.

The patients are referred to the Clinic by schools, nurseries, medical clinics, health nurses, etc. Family histories are taken by the social worker in the patient's home. The Clinic is held once a week but the patients may see also the social worker in between the Clinic days.

The purpose of this thesis is to outline and discuss some of the typical problems which are found frequently in mothers of problem children. These problems concern the mothers' attitudes toward the child as well as their attitudes towards life in general. An indication of the dif-

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ficulties involved in treatment and clinical contact with these various types of problem mothers is given.

The scope of the thesis is limited to eight cases which are discussed in detail and arranged in such a way that two cases are used to illustrate one particular problem.

The sources of the data were the records of the agency, the interviews with the mothers and the children, and the observations made by the writer at the Clinic and pertinent psychological, psychiatric and social work literature. The social histories were compiled summarizing the agency case records. Pertinent materials were selected from the bibliography for criteria against which to study the findings. The records were selected specifically to illustrate the problems of mothers, which were found frequently.

CHAPTER II

1. DISCUSSION OF THE MOTHER-CHILD RELATIONSHIP FROM THE STANDPOINT OF THE CHILD

A child guidance clinic deals in the first place with the acute problems of children. Dynamic psychology has made it clear that the child's problems represent symptomatic behavior, are reactions to and an expression of a conflict between antagonistic tendencies. The problem finds expression and some sort of solution in the symptom which, therefore, is always an underlying difficulty. In order to interpret its meaning one has to think of human life in terms of totalities, i.e., one has to see it as an integration of the whole (in the last analysis biologically determined) person with the whole situation. In interpreting and analyzing this totality there are always many interrelated causative factors with the adult and with the child.

The younger the child the more these interacting forces will be within the family constellation, the more they will be confined to the scene of the "family drama where the different but related roles of father-mother-child,

the basic roles in any culture,"[1] are being played. Allen emphasizes that it is the family which determines these roles "which are different but which must be lived in relation to each other with the emphasis on the child role as it gains its direction and meaning through the functioning of the adult roles of father and mother who, at the same time are husband and wife."[2] The process of individualization starts for the child at birth. Sutty says the infant "cannot appreciate the distinction between himself and its mother." That means that the essential dynamics in the growth of the child lies in "the differentiating process as mother and child perceive these emerging differences and the ensuing feelings of separateness."[3] What is self and what is not self becomes determined in that growth process which at times may take the form of a struggle of the child against giving up the mother as an undifferentiated part of himself. He may attempt to retain what growth requires him to give up. Only through these steps of differentiating himself from the mother does reality emerge. "The child must move out of the more total infantile relationship"[4] if growth toward independent living is to take

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1 F. H. Allen, "Dynamics of Roles as Determined in the Structure of the Family," American Journal of Orthopsychiatry, 12:127, January, 1942.

2 Ibid.

3 J. A. Suttie, The Origins of Love and Hate (London: K. Paul, Trench, Trübner & Company, 1935), p. 136.

4 Allen, op. cit., p. 128.

place. The child learns that the mother is not always available, that she has other functions besides caring for him, that there is a father and that mother has experiences with him which do not include the child. That "drama of individuation and self-differentiation," as Allen calls it, involves positive satisfaction for the child, as well as a feeling of loss which stirs up anxiety, and the wish to recapture what has been lost. To a certain degree disturbance is always inherent in the growth process but its extent depends upon the way in which "individuals give meaning and value to the roles they must live."[5] The child might fight to hold the mother because the mother has failed to give the child opportunity for growth and independence. The mother's difficulty in turn may be due to the failure of the father in his role as a father or a husband. Allen states: "A...positive understanding of growth will follow from a functional conception of the interrelated and concurrently operating forces in mother, father and child as they live their appropriate roles."[6] When one fails the balance is lost.

Therefore the reactions of the father, the mother and the child cannot be treated as separate phenomena because they are only different aspects of the same "drama of growth and self-definition."[7] That does not imply, how-

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5 Allen, op. cit., p. 130.
6 Ibid.
7 Ibid.

ever, that one is justified in assuming that all problems coming up at a child guidance clinic are the result of disturbed parental relationships. B. Rank[8] and E. Jackson[9] only recently pointed to the effect which a traumatic experience such "as sickness in which the child has been on the brink of death," an operation, or inability to master such conflicts as the fear of masturbation, which may exist even where no threats are used, may have. In these cases the trauma will have a different weight if it is the one disturbing factor in a comparatively healthy and happy background of relationships than if it will be another source of difficulty in addition to other problems which will color and aggravate its meaning.

Since it has been realized that the problem of the child cannot be separated from the whole interplay of family relationships, the child guidance clinic tries to approach the whole phenomenon in working with parents and child, or at least with mother and child. In special cases only has the method been used of working just with the parents, or with the child alone.

The parental attitude is equally important as a

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8 B. Rank, "Discussion of E. B. Jackson's 'Treatment of Young Children in the Hospital,'" American Journal of Orthopsychiatry, 12:65, January, 1942.

9 E. B. Jackson, "Treatment of Young Children in the Hospital," American Journal of Orthopsychiatry, 12:58, January, 1942.

diagnostic and as a treatment factor. Lee Yugend expresses that thought when writing:

> Although it is the child who is referred to us... we cannot hope to help him unless we see him in relation to his family group and the influences surrounding him, since, in the last analysis, these constitute the soil in which he has to grow.[10]

Tiffany-Burlingham, discussing the similar difficulties of child analysis, says:

> After successfully completed analysis the adult knows what to do with his released potentialities. The child as a child needs still to be guided and helped.[11]

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10 L. Yugend, "The Role of Parental Attitudes in the Treatment of Diseases in Children," Mental Hygiene, 25:58, October, 1941.

11 D. Tiffany-Burlingham, "Child Analysis and the Mother," Psychiatric Quarterly, 4:357, 1935.

2. DISCUSSION OF THE MOTHER-CHILD RELATIONSHIP FROM THE STANDPOINT OF THE MOTHER

The aspects of origin, development and nature of the mother-child relationship have often been discussed from the standpoint of the child, but rarely from that of the mother. It is interesting to look a little more closely into some of the factors which determine the affective reactions of the mother to the child.

There is, on the one hand, an instinctive disposition which manifests itself in an emotion which has been named by McDougall "tender emotion." The energy of that emotion varies greatly. On the other hand, hostile feelings, conditioned by jealousy and frustration, may arise in the parent. They are usually repressed and confined to the unconscious, and can be discovered only indirectly through their manifestations. Fluegal, in his study of the family, stresses these ambivalent feelings of the parents. He writes:

> If it be to some extent inevitable that children should come to regard their parents as obstacles to the full attainment of their own desires and as unwelcome causes of interference with their most cherished activities, parents have at least equal reason to complain similarly of their children.[12]

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12 J. C. Fluegel, Psychoanalytic Study of the Family (London: Hogarth Press, 1935), p. 167.

The responsibility, the effort, the anxiety in bringing up children diminish the energy and time available for other enjoyment.

> To some extent the individual sacrifices himself in becoming a parent in accordance with the general law which Spencer has designated as the antagonism between individuation and genesis, and this sacrifice of personal comforts, pleasures, satisfactions and ambitions does not as a rule take place without some degree of resentment being felt at those whose existence necessitates the sacrifice.[13]

Especially the mother, upon whose time and energy so great a demand is made, may feel the constant presence of a child at times as a nuisance and a menace, and she may experience hostile feelings toward him, "though the existence of a strong counter-impulse towards maternal love will often insure repression of these feelings into the unconscious."[14]

Another factor involved is a process of identifying the child with his grandparent. Jones and Frazer have called attention to this phenomenon which, according to them, is deeply implanted in human nature and appears in some cultures as the belief that grandparents are reincarnated in their grandchildren. That would explain the general tendency in parents to repeat the patterns they have experienced with their parents in rearing their own children. Though conscious resentment against this pattern may exist, there is still an unconscious tendency to

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13 Fluegel, op. cit., p. 167.
14 Ibid., p. 169.

repeat it, and to take revenge for the real or alleged injuries which the parents suffered in their childhood.

The fact that the child is the natural successor of the parent causes two different and contradicting attitudes in the parent--one of envy and hatred, and another of love. The first is accounted for by the realization that the child will soon be equal or even superior to the parent in many important aspects of life. Pride and self-love of the parent may easily be hurt by the awareness of increasing failure in his (or her) own power, and bitterness against the child may arise.

The second attitude consists of a process by virtue of which the parent identifies himself with the child--"as it were incorporates the child into his larger self and is thus able to take pleasure in the increasing powers of the child as if they were his own."[15] As the child tends to identify himself with his parents in order to increase his power, so, and for similar reasons, the parent identifies himself with the child. Thus he finds compensation for the diminution of his personal capacity and he experiences some fulfillment of his wish for immortality. In this way the parent does not only gain a prolongation of his existence, but he is also able to enjoy pleasures and successes of which he, as an individual, has been deprived and which

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15 Fluegel, op. cit., p. 171.

he achieves vicariously through his children.

This process of identification has another aspect--the possessiveness of the parent, especially the mother. Just as the infant feels the mother as a part of himself in his early life, so the mother will be inclined to see the child as her child, as a part of her even after birth, as belonging to her, and owned by her. The great helplessness of the child for a long time after his birth, his dependence on his mother's protection and care, gives the mother the directive power over his life and the responsibility for his well-being.

These mechanisms of identification and possession represent the most effective incentives for the mother to provide good care for her child--as her second self and her possession--and are thus in some way a reconciliation of egoistic and altruistic trends. At the same time, however, these mechanisms represent the greatest danger to the further development of the child and to the equilibrium of the mother, because they are opposed to the main principle upon which human intercourse is based--respect for a different personality. The successful development of the child requires an ever-increasing emancipation from the ties of affection and dependence which bind him to the parent, and the parent needs a corresponding loosening of his identification lest great frustrations of his hopes may occur.

> An undue prolongation of the tendencies natural to the early days of parenthood must necessarily in the long run be detrimental to the true interest both of child and parent.[16]

Nevertheless there will always be a temptation for the mother to prolong protection too extensively, to exercise authority and control over the child, to take responsibility from him, to keep possession of him under the disguise of altruistic tendencies, and to deny him the right of making his own experiences.

In summarizing, it can be said that even under favorable, so-called "normal" conditions, the mother-child relationship is liable to many conflicts. There are tendencies to jealousy, frustration and struggle on the mother's side as well as on that of the child, and all "that can be reasonably hoped for is that such degree of jealousy as may be unavoidable throughout be held in check by feelings of affection."[17] Unconscious ambivalent feelings will generally be a factor playing a part in the filio-parent relationship, and will provide an atmosphere in which tension and conflict can easily arise if any personal maladjustment of the mother occurs.

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16 Fluegel, op. cit., p. 172.
17 Ibid.

3. RELATION BETWEEN MOTHER'S AND CHILDREN'S PROBLEMS

The patients at a child guidance clinic present a variety of emotional and behavior problems and symptoms, and their mothers present mahy significant attitudes.

Each case is individual and the interplay of determining forces is unique, yet there are constantly recurring patterns of typical maternal attitudes, usually resulting in failure, which can be observed in many cases. The involved problems of the mothers always influence the child in his growth and development, as it has been observed by many authors. In this sense Tiffany-Burlingham remarked that "the power of unconscious forces is especially marked in its interplay between parent and child. It is so subtle and uncanny that it seems at times to approach the supernatural."[18] Silberpfennig states that the child reacts to his mother's behavior and that his reactions are closely related to and produced by her problems.[19] It is the "attitude of the mother rather than anything particular she may actually do"[20] which is so important, as Field stresses, and

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18 Tiffany-Burlingham, op. cit., p. 358.

19 J. Silberpfennig, "Mother Types Encountered in Child Guidance Clinics," American Journal of Orthopsychiatry, 11:483, July, 1941.

20 M. Field, "Maternal Attitude Found in 25 Cases of Children with Behavior Primary Disorders," American Journal of Orthopsychiatry, 10:309, April, 1940.

Glueck points to the same phenomenon when he refers to the "atmosphere" and the "intangible forces for good and evil which are implicit in the situation."[21] Purette formulates the same thought by saying that "not all the advices by baby doctors, not all the books on psychology, not all the theories on child care and training are one tenth as important as the kind of woman the mother really is."[22]

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21 B. Glueck, "The Significance of Parental Attitudes for the Destiny of the Individual," Mental Hygiene, 12:4, October, 1928.

22 L. Purette, The Parent and the Happy Child (New York: H. Holt and Company, 1932), p. 15.

CHAPTER III

1. DELINQUENT MOTHERS

Two viewpoints practically overlapping each other are essential in considering any personality problem: the strength and maturity of the ego and the early libidinal relationships.

Freud in discussing the first view has shown that the functioning of all our activities is automatically regulated by a basic tendency to attain pleasure and to avoid pain. The unconscious, which is the source of all psychic life and from where all instincts and wishes arise, is governed exclusively by that principle which Freud has called the pleasure principle. Any tension in the organic system is felt as pain and produces a need for discharge. And any release from tension is felt as gratification or pleasure. The outer world, however, does not always conform to the individual's need for pleasure. The infant, dominated by its instinctual demands, ignores reality, and disappointment, and pain instead of satisfaction are frequently the result. As the psychic apparatus of the child grows and develops he adapts himself more and more to the

demands of life. He learns gradually to renounce the pleasure of immediate gratification in order to avoid the resulting pain and to gain greater pleasure later on. Pleasure has to be postponed, often, because of the difficulties opposing gratification, or because the pain which results from the gratification of instincts in a way which is unacceptable to society.

This suppression of instinctual needs in order to achieve postponed gratification and to avoid pain, establishes a second tendency, the reality principle. This principle designates an important step in mental development and leads to the organization of the conscious ego which takes notice of the outer circumstances of life, i.e. of reality, and protects the individual from being harmed. The stronger the reality principle the stronger is also the ego and the more capable it is defending itself against instinctual demands. As Aichhorn puts it:

> The reality principle enables the child to make adjustments between his desires of pleasure and the demands of life. When the child is very young and his capacity for adjustment to reality is still weak, the ego demands immediate instinctual satisfaction and is less able to forego pleasure and to endure pain. We can define the different stages of the child's development according to the degree in which the pleasure principle predominates over the reality principle.[1]

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1 A. Aichhorn, Wayward Youth (New York: The Viking Press, 1935), p. 194.

The first adaptations to reality are biologically determined but further progress in the sense of social adaptability is achieved through education. It must be kept in mind that: "Adaptation to reality involves renunciation."[2] The capacity of an individual to adjust himself to reality depends less on the nature of the renunciations required than on the relative strength of the ego compared with the strength of the instinctual demands. That ratio varies with different individuals and is chiefly determined by constitutional endowment, i.e. by the strength of the physiological drives. Here the constitutional factor, the importance of which is sometimes reduced to a minimum in modern psychiatry, keeps definitely its place.

The records of the Child Guidance Clinic show that a great percentage of the problem mothers bringing their children to the clinic are still as dominated by the pleasure principle as they were in early childhood. They are not able to give up immediate pleasure in favor of later pleasure or in favor of the child. A part of their personality is still dominated by the over-powerful pleasure principle and seems to have failed in making the step to the reality principle. We know that Aichhorn has described delinquency as "the consequence of an inhibition of development or of a regression which takes place somewhere along

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2 Aichhorn, op. cit., p. 199.

the path from primitive reality adaptation to social adaptation" and he describes the delinquent as one "disturbed in his ego development." We are therefore not surprised that many of these mothers had a delinquency record in their past. These mothers are driven by their instincts, seek gratification for any desire and "reality with its later unpleasant consequences does not exist for them at the moment."[3] After all has been said about the close interrelatedness of mothers' problems with child behavior, one can expect to find deep disturbances in the children brought up by these mothers. To quote Preston, "one infant cannot possibly teach another infant to be an adult."[4] Field in her study on maternal attitudes of children with behavior primary disorder refers to this type of mother by stating that she did not find a single "well-integrated individual, functioning adequately and discharging her duties as wife and mother in an adult fashion."[5]

The following two cases may illustrate the connection between the mother's lack of ego strength and the child's problem.

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3 Aichhorn, op. cit., p. 199.
4 G. H. J. Preston, "Mental Hygiene Factors in Parental Relationships," Mental Hygiene, 12:5, October, 1928.
5 Field, op. cit., p. 295.

Case of Walter S.

Walter S, 5 years old, has been referred to the Clinic because of his compulsive behavior. At the age of two years he started, as a game, what has now become an obsessional trait: opening and shutting doors and preoccupation with keys and locks. When he was three he climbed on a chair and opened and shut the door for hours. His mother describe his interest in keys and locks as a "fascination." He always has keys in his pocket and when walking along the street he tries to open the doors of the houses with them. He collects them like a miser until he has all the keys in the house. His mother cannot take him for a visit because he asks for the key of the mailbox wherever she takes him. In the evening he puts all the keys in the house under his pillow when he goes to bed. In the morning he hides them somewhere or puts them in his pocket. The mother has to promise to leave them underneath the pillow while he is asleep. Walter's constant opening and shutting of the doors in a compulsive way irritates the whole family considerably.

The birth was normal. He was breast fed until seven months and walked and talked at a normal age. He sucked his thumb up to four years of age and was enuretic and nocturnal until his third year.

He is demonstrative in his love to his mother and dependent on her. He cries as soon as she leaves him alone

and refused to do his psychological test without her. He is not self-reliant in any way, is irresponsible and disobedient. His I.Q. is normal.

He has a three year old brother who is also a patient at the Clinic, referred for his destructiveness, aggression and tantrums. The family is Jewish. The father is an asbestos worker making $35.00 a week.

The mother: The mother is overly affectionate in her behavior towards the children and indulgent in tenderness. She is an intelligent, alert and vivid person. Her face has an expression of vigilance. She is of Russian stock and somewhat Asiatic looking. Most striking is her extreme need for "body pleasure" of any kind and the unrestrained and indulgent manner in which she ministers to her desires. In gratifying them she follows an infantile pattern, i.e. she is unable to postpone any pleasure and insists on immediate gratification. If she wants a cigarette she has to have it immediately although smoking is prohibited in the Clinic and she has been asked to wait until she is outside. In the middle of the interview with the worker at her home she gets up to make herself a cup of coffee. She eats candies and smokes while being interviewed. Apparently she satisfies her exhibitionistic wishes and her need for lavish tenderness in the same unrestrained and careless way as in her oral demands. The writer heard her say to the boy, "will you go to the toilet with mother, dear? Mother goes to the

toilet," and she took him with her. And again, Mother: "Did you give mother a kiss today?" Walter: "Yes." Mother: "I think you didn't," and she urged him to kiss her. Her discipline with the children is as lax as her self-discipline, which does not exclude her exposing them to terrible temper tantrums and outbreaks if she feels like it. When the younger boy hit her, threw her coat on the floor and spit on the floor, she only said, "is that nice?" At other times she shouts at the children.

This mother's history confirmed the worker's first impression that she was not able to deny herself anything, had never overcome an infantile pattern of immediate gratification and did not follow the reality principle despite her normal intelligence.

Mother (Rose S.) was born an illegitimate child. The maternal grandfather was a traveling salesman and a drug addict. He had served a sentence at the House of Correction for larceny. When the mother was two and one-half years old the maternal grandfather took her to the home of his sister and his father. Rose was brought up by them, was given much freedom and was pampered and pitied. At the age of fourteen Rose was referred to a guidance clinic from a girl's high school because she circulated obscene literature among the girls. Two years later, she was charged with shop-lifting and was brought into Juvenile Court. She had stolen a neck-

lace and three pairs of stockings in a department store and confessed to having taken hose on previous occasions. She was found to be a delinquent and placed on probation. Two months later she was discovered to be in her sixth month of pregnancy. She named two boys, one of whom was paroled from a state correctional institution. Rose was again referred to a guidance clinic and was seen by the psychiatrist many times. She was considered to be a friendly, alert girl of good mental ability (I.Q. 106), quick in her responses, good in apperception, stable emotionally, likeable and happy, and excessive in her sex drive. The girl was placed in a home for unmarried mothers. She refused to do her share in the work and nothing could induce her to change. She was then placed in a hospital where she gave birth to a baby girl who was placed in a boarding home by a children's agency. After her discharge, Rose returned to her aunt and worked, paying three dollars a week on the board for her child. Her family wanted her to release the child for adoption but she refused until one year later when she consented.

Later it was learned that she was pregnant again and her second child, Norma, was born. A few years after this, she married Louis S. who had just been released from prison. She claimed that she had had relations with him before and that he was the father of her child, but this

seemed doubtful. Shortly after marriage he stole a fur coat and was returned to the reformatory. Rose lived with her mother-in-law and worked in a hat store. She was devoted to the baby, sent her to the day nursery and took good care of her. Her husband was expected to be back from prison in eleven months. In the meantime Rose was interested in various other men, went to dances and movies with them, but visited her husband often. She was also interested in an Irish boy whom she had known for a long time. She said she did not know that she could love two men at the same time and asked the psychiatrist whether she should leave her husband. She was advised to do so but she said that she had known him since he was a little boy and that she loved him and wanted to give him a last chance before making up her mind. At the same time she fell in love with another man she had met and her "heart ran away with her head." When her husband returned they lived together for a short time, then she sent him away to visit his family and a few days later her third illegitimate child was born. Her husband knew nothing about his coming. Rose was in good physical condition. The baby was born Tuesday, Wednesday she was up cleaning the house and Sunday out walking with her husband. On the street while he was quarreling with Rose, an officer approached him and arrested him on the charge of larceny which he had committed since his release.

Rose is quite proud of the fact that all three of her children have different fathers. She refused to tell the name of the father of this child but named it Jaqueline, because the father's name was Jack. She assumed a demanding attitude at the Clinic. She thinks that her children may be proud of her and that she is befriending society by bringing into the world such fine children. She placed Jaqueline with an agency and moved with Norma to the home of maternal grandfather's former wife from whom he was separated. She became involved in larceny with her twice. After her husband's discharge, Rose lived with him and "it was one of the happiest times in my life." After the two boys were born, her husband went to prison again and she had other lovers. She always took him back when he returned. Norma lives with them but was never seen at the Clinic.

This mother with her underworld background is an affectionate person, genuinely fond of her children, enjoying and accepting life, and she is of good intelligence. In spite of all these positive attitudes her life has been unacceptable socially. The children's problems are, to a great extent, responses to her maladjustment and the lack of mastery of her vital energies, though all the other factors involved (father, heredity, etc.) must not be forgotten. She is determined to satisfy her strong drives at

once, refuses to accept any of the restrictions which society may impose, and she became involved in delinquencies when she was young. The same pattern is shown in her stealing as in her attitude towards sex: she takes what she desires without delay, no matter what the consequences may be. She has not learned to refrain from any kind of wishfulfillment with regard to reality. It was felt that Walter's obsessional behavior was probably connected with his mother's careless indulgence in pleasure. She used to lock him out when she had her lovers with her and she says that the boy looked through the keyhole of the door so he could see what was going on in the room. This may have aroused his anxiety which in turn could have led to his compulsive need for the opening and shutting of doors and the hoarding of keys as fetishes.

Another example of a mother who follows her drives without taking responsibility for the consequences is in the case of Mary L.

Case of Mary L:

Mary, seven years of age, was brought to the Clinic by her mother because of her stealing and destructive behavior. She takes money when mother leaves it on the table or sends her to the store. She took gloves and other belongings of children in school, destroyed or hid them.

Once she took a penny from the teacher's desk which penny was later found in her shoe. She stole milk and crackers from the school basement and took an ice cream cone away from a child in the street and ran away with it. When questioned in school about her stealing she lies and denies it even if it is quite evident. She is quiet and withdrawn, shows no interest or sign of affection for anyone in the family. When mother bought her a new winter coat, she cut it to pieces. She tore all the buttons from her sweater, and threw her sneakers out of the window. She never shares anything with her siblings. She picks up candies from the ground and eats them. She is shy and does not mix with the other children of the neighborhood who call her a thief. But she never attacks a child. One evening mother sent her to the store to buy some bread. When Mary did not return, the mother notified the police who found her at two o'clock in the morning sitting on the doorstep of a house in a distant section of town. There is also a problem of masturbation. Mother "caught" her masturbating, both during the night and the day time. She slapped her hands, threatened her, and she she was a very bad girl. When mother returned from the hospital with the baby after the delivery, Mary "deliberately" wet the bed. In school she did not do what she was told, was inattentive, lied when she was late, and destroyed everything, especially

with her mouth and teeth. She chewed the letter cards and pieces of blotting paper and spit them on the floor. She destroyed the boxes of the children, was restless and wandered about the room. Her intellectual level is borderline. Mary is a husky little girl, dirty in appearance and poorly and carelessly dressed.

Mary was born an illegitimate child in between two marriages. Her birth, dentition, walking, talking were normal. She was breast fed for ten days. At the age of six months she was placed in a private fosterhome but after some months she was removed because the mother had defaulted in her payments. Then Mary was placed in a country home by a child welfare agency. She was a healthy, active, vigorous child and was but wilful and sociable. She liked outdoor games. The foster mother was a simple but kind woman. The mother did not visit her once but when Mary was four years old she took her back home, since she had married for the second time.

The mother is an untidy, stout, Irish woman, limited mentally, has a rheumatic heart condition and shows extreme irritability. At the slightest provocation she screams and shouts so that she can be heard throughout the house. The husband is an Italian who earns $25 a week on the W.P.A. She has five children by her second husband. The youngest is a baby of six months. They live in a very poor Italian section.

The mother: Maternal grandmother died when mother was born and she was brought up by her aunt and her uncle. She called her aunt "mother." They were good to her and spoiled her a great deal. The mother's two brothers stayed with maternal grandfather. They are policemen now. The mother did not like school and went only to the seventh grade. She remained in her uncle's house and worked in a candy factory. When she was 17 she was charged with having sexual relations with an Italian, and was on probation until she married him at 18. They had four children. Their married life was unhappy and quarrelsome. The mother claimed he spent too much money, gave her too little, abused and beat her. Once she drank iodine after a quarrel. Finally she told him to leave the house, after a fight, and he did. He paid her $15 a week and she kept the children. When he learned that she was drinking, having sexual relations with other men, was pragnant, and had attempted an abortion, he decided that she was not the proper guardian for the children and removed them to the home of his sister with whom he lived. His story was confirmed by mother's brother who had visited her home and had found the baby alone, no food in the house, and it was cold. The mother paid no rent, spent no money for the children, but used it all for herself. She did not take care of them but frequently went on drinking parties with other men. She was promiscuous

with many men, among them a much younger man, George L. who is Mary's alleged father. This boy said he came to her house with some friends, they drank, he was intoxicated and when he woke up in the morning he found himself in bed with her. He called her a "loose character" and believes the other friends had relations with her, too. She and George were arrested some time later on a charge of sexual misconduct and she did not know his last name. They were placed on probation. A month later she was pregnant. George was adjudicated the father and was ordered to pay four dollars a week after Mary was born. The mother worked as a maid and paid one dollar. The child was placed in a private foster home under the supervision of the court. Then soon the mother defaulted and disappeared. It was at this time that Mary was placed by the city in a country home. The mother in the meantime was living with an Italian, Rosario L. and remained with him for one year. They were charged with "Lewd and Licentious" conduct. Their son was born later and placed with Mary in her foster home. Later this man married the mother and Mary and the boy were discharged to her upon her request. When the Probation Officer visited the home he found Mary in a chair, afraid to move and learned that she was being disciplined because she was unable to get along with her mother and the other children. She was used to outdoor life and resented the crowded poor home. She

disliked the food and insisted on candies. The mother requested that the child be again removed and neither she nor her husband wanted to care for her. When the Probation Officer came the next time, they had changed their minds and wanted her to stay since she was a help for the mother with the babies.

This mother, too, was a delinquent, who, driven by her instincts, did not take any responsibility for the consequences. The child was placed in one home then into another. The mother did not visit her and when she took her home, Mary found it very hard to adjust herself to the small home and to the mother's rough attitude, her quickly aroused temper and her cruel punishments. She resorted to masturbation, but was caught, punished and threatened by the mother. The worst of all was that Mary has no emotional tie, does not like anyone. She is too afraid and withdrawn to direct her aggression against people but expresses it in destroying objects, especially thing which her mother gives her, thus displacing her hatred from the mother to the object. The only pleasure in which she takes refuge seems to be the oral one. She indulges in oral activities, eats greater quantitities than is to be expected for her age and steals candy and sweets in the stores, in school and from children, having no incentive in her mother's love to abandon her behavior. She takes what she wants. She not only likes to eat things but also to destroy them by chewing.

* * *

There are certain similarities between these two mothers described above. Both had no mothers and were brought up by relatives who pitied, pampered and indulged them a great deal. Both committed sex delinquencies at an early age, were put on probation, but no reconstructive treatment changed their behavior. Both had court records, lived promiscuously and for the moment's pleasure only, without taking responsibility for the consequences. Each had a very immature ego and weak superego, and both are in open conflict with the standards of society. There are also many differences, the most important being the attitude of the child. Walter's mother is affectionate and weak, indulges and spoils the child with tenderness and keeps him too close to her, whereas Mary's mother is rough and harsh and neglectful of the child. The mothers come from different backgrounds; Walter's mother is of Russian-Jewish stock, his maternal grandfather had been a drug addict and a figure of the criminal world, whereas Mary's mother comes from an Irish family with good social standing, her brothers are policemen and her cousins teachers.

Treatment implications: This group of mothers who are designated as delinquent mothers present great difficulties as clients at a child guidance clinic. First of all, they are past the age of adolescence which appears to be the last chance for an individual to adjust to the

standards of society and to develop an ego-ideal which, as a conscience, regulates the instinctual drives. Aichhorn[6] has stressed the importance of adolescence in this respect and has commented on the last possibilities for reorientation which it provides. When this last chance has been missed, there is little hope that it will be possible to modify the pattern which has become already fixed.

Secondly, the delinquent mother is very apt to identify the Clinic with authority and society, i.e. with all these forces of the super-ego which she has defied. She comes to the Clinic, however, to get help for her child or for herself. She is willing to accept these powers within a certain limited area, that is, the actual problem of the child. She does not realize when she comes to the Clinic that she herself is in any way connected with that problem; she does not accept that she and her past will become subject to study. As soon as she feels the attention centered upon herself, she becomes defensive, evasive and hostile. She is resentful and fearful that her court record may be discovered and she protects herself with all the means at her disposal. The Clinic, her friend, and ally, in the beginning, is looked upon at once as an enemy, a threat like authority and law. She is very likely to identify herself with the misconduct of the child and to

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6 Aichhorn, op. cit.

withdraw from the Clinic. The weapons used to protect herself vary with the mother's personality. Walter's mother, who is a clever and friendly person, told the worker right away when her personal life was approached that she did not want to tell much about her life. She said, "I don't lie to you, what I say is the truth, but there are many things I do not want to talk about."

Mary's mother, a stupid, excitable and aggressive woman, resorted first to lies by giving false information and finally when her marriage was touched, shouted in a very hostile manner that she could not see what that had to do with Mary's problem. But in either case, a pronounced resentment and nervousness in the mother could be felt as soon as any such danger zone was approached. This was the signal for the history taking social worker to be careful and not to antagonize the mother. In such cases if it is not possible to work with the child himself, quickly and successfully, the case will very likely have to be closed soon. The mother gives as an excuse that the Clinic cannot help her child, as Walter's mother did, or that she has changed her mind, as Mary's mother said. She asked for temporary placement of the child, but when the Clinic tried to work with her she withdrew and said that she had changed her mind and wanted to keep the child and did not need any help--"the child would be all right later." At this point the

greatest skill of the social worker is necessary to help the mother continue her visits to the Clinic.

2. PERFECTIONISTIC MOTHERS

It has been emphasized in the foregoing chapter that the early relationships are largely responsible for the formation of personality problems. In early childhood the instinctual drives of the child are diverted from their original primitive goals to higher socially acceptable goals by love and fear of the parents. Instinctual gratifications are renounced in order to comply with the demands of the parents to keep their love. To facilitate that difficult task the child identifies himself with the parent, he incorporates, so to speak, the parent within himself as a helper for his own weak ego, and looks with the parent's eyes upon the world. These incorporated parental demands and prohibitions will later on form a part of his ego, the superego. This critical faculty observes and judges the behavior of the ego and praises and punishes the ego. Thus the influence of the parental demands continues after identification and assumes the character of a categorical imperative from within. If a child identifies himself with criminal parents he may develop a super-ego not acceptable to society. As Aichhorn says, "the normal ego-ideal goes astray when it takes over unacceptable traits from the parents."[7] This was apparently the case with Walter's

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7 Aichhorn, op. cit., p. 213.

mother. Socially acceptable behavior is preserved by the ego-ideal which dominates the ego, and "to be social means to have an ego which can subordinate itself to authority without conflict,"[8] as Aichhorn states it. The two mothers described above showed an extremely weak super-ego and were following their "free floating libido" without restraint and without orientation to values and imperatives governing the course of behavior.

The formation of a "socially directed ego-ideal cannot take place if the nucleus of the ego-ideal, which is based on the first great love objects, is weak or non-existent."[9] It is important to consider what happens, on the other hand, if the ego-ideal is too severe and too rigid in its demands upon the ego. The ego in its turn too weak to meet these demands, will attempt to withdraw and to defend itself against them. But the super-ego will not give up the struggle and will release guilt feelings in the ego. If the pressure becomes too strong the ego either has to submit to the commands of the super-ego or to use the defense mechanism at its disposal to cope with unbearable situations, that is, repress the guilt feelings. These feelings, though unconscious, will continue to disturb the peace and harmony of the ego and the individual may become rebellious and insubordinate to provoke punishment.

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8 Aichhorn, op. cit., p. 217.
9 Ibid.

In the following two cases presented the mother, under command of her own rigid ego-ideal, makes exaggerated demands upon the child.

Case of Fred T:

Fred T, a boy of high intelligence (I.Q. 128), twelve years old, is referred to the Clinic because of his social maladjustment and his lack of self-control and stability. He antagonizes the teacher and the children of his class as well as of the neighborhood by his behavior and has no friends. He cannot be quiet and is rebellious and unsocial at school. He argues in class with the teacher, talking at length about everything without coming to the point. He questions and criticizes the work of the teacher, does not submit to discipline, is inclined to give inadequate recitations and to make himself generally obnoxious. As soon as he starts speaking he says the wrong thing. He wants a lot of attention just for the sake of talking and irritating the class and never adjusts himself to the group. He annoys the children and has nobody with whom to walk home. Often he comes home crying and complaining about the teacher and the children. In school he likes to assume the role of a policeman and as soon as the slightest offense against a rule occurs he is the first to rush to the teacher and principal complaining and "tattling" even though it is no concern of his. One of his favored complaints is that the

boys have attacked him. He puts all the blame on them, saying that he did not do anything. In one of these episodes, however, it has been found that Fred had made deprecatory remarks in class about other boys' religions and had said aloud that their religion was not good. As a consequence the boys "beat him up" on his way home. Fred is one of the biggest and strongest boys in his class, nevertheless he cannot stand up for his rights and always goes to the teacher for protection. If the teacher asks him why he does not defend himself, and fight back, he says, "I admit I can't fight."

The history of Fred's early development has been normal except for the fact that he had enuresis nocturna until he was seven years of age. He comes from a middle-class home, his father is a college graduate, and his mother a former teacher of physical education. He has a sister of seven who like Fred is a bright but restless, nervous child. They live in their own large, one-family house in a residential area near Boston.

The mother: Fred's mother is a delicate, blonde woman with regular features. She is always in a hurry and is on her way to carry out her enormous program of volunteer activities. She does so many things and takes so many outside activities upon herself that the day should have forty-eight hours. She works for the Community Chest, the Red

Cross, the Family Service Bureau of her church, she is Cub Scout den mother and is in a church club. Besides these activities she has the care of the two children and the entire house. Like her son she likes to indulge in a stream of words and to dwell on unimportant details. At times she talks like a book and there is always some exaggeration and mannerism in her way of talking. Everything connected with her family loses all proportion and grows to enormous dimensions in her mind. She has evidently lost all sense of proportion in relation to the fact that Fred is a little boy who should play and fight like other boys and whose behavior is of no special importance to the world. She speaks of him in high-strung and assuming terms, such as "he has so much to give to the world" or "the world can not afford to lose a person like that who has so much to give;" yet she complains that "he does not give what he has to the world" and blames herself for not having been strict enough. The mother feels "the community is ours, we are proud of it and have to work for it," and has started to drill the boy for his social duties to humanity from his early days. Social activities have been forced upon him. She has arranged for scout meetings at her house, and under her supervision as den mother. He was in the W.M.C.A. and is in a church group. When he said he would like to give up the scouts, a great issue was made of it and the father,

an assistant scout master himself, threatened it would be an irrevocable decision. Fred has to deliver envelopes for the Community Chest and he and his sister have to make twenty paper bags every day for the Red Cross. He has to clean his room and shine his father's shoes and gets paid for this. He must give account of the use of his money and a spending budget is made up by his mother: so much for the church, for the scouts and for the Red Cross. Only a small remainder is at his disposal. He has been taught not to fight back and to lead a life of "service." He is allowed to go to the movies very seldom and only to approved pictures. He is not permitted to use fire crackers like the other boys or to read the comics. His mother says with great indignation, "such stuff must not come into her house." Not all radio programs are allowed. The mother comments in a complacent way on how devoted Fred is to the community.

As a matter of fact, Fred talks in a premature and over-conscientious way about social duties, using terms beyond his age, such as how wonderful it is to live in a place where all the neighbors like each other. But when he talks of single individuals he sounds hostile. He told the worker about a boy who is rich and spoiled and never has to help at home, and he adds self-righteously and defiantly, "why do you think mother has time for everything and other's don't? Because her children help her while other children

don't help their mothers." A hostile feeling is also event when he calls a boy who does not attend their scout meeting a "quitter."

The mother: The mother was one of ten children, maternal grandfather died when she was seven years old. Maternal grandmother was strict and domineering, never discussing anything with her children. The mother had no idea where their money came from, what money means, and about prices. Maternal grandmother taught them obedience and there was never any question as to the why of a command. The mother's twin sister rebelled against this tyranny, but to no avail so the mother submitted. Her twin sister was very popular with boys while she felt inferior and tried to make up for it by sports. She studied physical education. Later she married the father whom she had known from childhood. He was an unsocial, withdrawing, introverted person and the mother took much pride in helping him in his social adjustment. She really succeeded for he became so community minded that he has all sorts of volunteer jobs in the community now, and is out of the house from six o'clock in the morning until twelve at night. The mother mentioned that she and the father had to make a "terrific" adjustment when they married. Neither of them had much sex information and she says "it is surprising that our baby was born eleven months after our marriage." Mother had no idea

about prices and it took her eighteen months before she knew how to handle money.

This mother has put so much over-emphasis on the issue of social duties and service that Fred, behind a surface of being a model citizen, feels thoroughly unsocial and has no genuine liking for people. He is neither able to form a friendly relationship with other children nor does he allow himself to fight and defend himself openly. Social activities seem to have the meaning of duties rather than of pleasure for him and he resents them. Under the pressure of mother's perfectionistic attitude and her assuming claims Fred has developed into a policeman who denounces the forbidden, envied pleasures of others.

A similar case, though different in some important aspects, is Ellen B's case.

Case of Ellen B:

Ellen, nine years old, in the fifth grade, a girl of good intelligence (I.Q. 111) is referred to the Clinic for poor school adjustment. She entered school at five years at her mother's request. Each year promotion becomes more questionable because of immaturity. She does poor work in spite of her intelligence, is extremely timid and insecure. The teacher complains that she speaks in such a low voice in her oral work that she cannot be heard. It

was suggested that she should repeat the grade. She is much smaller than the other children in her class, is handicapped in games, and is socially and emotionally at a lower level than the rest of the class. As a result she is unhappy at school. Nevertheless the mother is averse to the idea of her repeating a grade.

Ellen is the only child of a middle-class family. Her father is an electrician, the mother teaches in Sunday School. The family has an adequate income, their own car and house. The child was of full term and an instrument birth. Dentition, talking and walking were normal. She always had a finicky appetite, is a poor sleeper, suffers from night terrors. She has particular fears of hurricanes, thunderstorms and spiders. She always played with older children who imposed on her. Her mother says she has always acted "silly" in a group, crawled under the table or did something foolish and pointless. The other children played with her toys and looked upon her "as if she were some strange animal." She lacks independence and self-confidence. She is timid and apprehensive at home and very shy, answering questions in a low, subdued tone. The mother tried to place her in the junior choir at church, but she misbehaved so much that mother discontinued taking her there.

The mother: The mother is tense and nervous, a restless, discontented, unhappy person. She has a depressed,

dejected air and frowns constantly. She is over-earnest, overly conscientious and suspicious, and indulges in much self-criticism. She lacks all sense of humor. Ellen is obviously dependent on her mother, follows her around, and does what she does.

The mother graduated from high school and was a public health nurse for two years. Now she has few outside activities, and her only interest outside of the home is in church work. The mother had an unhappy childhood. The maternal grandmother died when she was five years old and she lived with an aunt until she was twelve. At this time she had to assume the major part of the responsibility for keeping house for the maternal grandfather and her younger sister. The mother felt all through her childhood that she was discriminated against because she had no mother. She always had trouble in school, repeated a grade and has never recovered from this disgrace. The mother married the father who is a quiet, reserved person. She does not like children and never enjoyed Ellen. However, she is ambitious for her, coaches her and finds her a serious challenge and problem. Recently the mother is beginning to be afraid that her ambitions will not be fulfilled because of Ellen's poor school adjustment. She refers to her little girl as "dumb" and admits that her affection for the child is only forced.

This mother, dominated by her rigid super-ego which

still punishes her with guilt feelings for her "failure" and disgrace, has pushed and coached her child relentlessly and has set achievement standards beyond her capacity. As a result Ellen was bound to meet with failure, which in turn increased her mother's disapproval and hostility. Ellen feels inferior and not accepted and the confidence in her own resources decreased as "there is only one way in which a hostile world can be dealt with--the ego shrinks like an amoeba."[10] The aggressive tendencies of mastery are organized around satisfying experiences only and become inhibited with failure. Work which is the direct expression of the technique of mastery becomes inhibited and the effectiveness of the ego seriously impaired as seen in Ellen's loss of self-esteem, in her depression and anxiety, her inhibition to do school work and her incapacity in making social contacts. Her subdued voice, which she hardly dares to raise, gives expression to her reduced status. Having lost confidence in her own resources, she becomes the more dependent upon her mother and the more dominated by her demands, which closes the vicious circle.

If these mothers are compared with each other definite similarities can be found. Both are imposing standards on their child which cannot be met in a natural way, both are governed by too strict ego-ideals and try to

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10 A. Kardiner, "The Role of Economic Security in the Adaptation of the Individual," The Family, 17:192, October, 1936.

transgress the limitations set by the reality situation. Both are given to much self-criticism and have adopted expectations as far as the child's performances are concerned, measured in terms of imperatives and ideals rather than of the child's needs, capacities and happiness. But there is, however, a great difference in their attitudes. Fred's mother accepts and loves her boy while Ellen's mother's forced affection cannot cover the lack of warmth and love in this relationship.

Treatment Implications: From the point of view of treatment this type of mother offers more possibilities than the mothers described in the previous chapter. It is evident that it is a more promising task to come to terms with an over-strict super-ego than to compromise with the inaccessible drives of the id. The perfectionistic mother looks upon the Clinic, which represents social order for her, as on a natural ally and is therefore inclined to accept the Clinic and to coöperate to the best of her capacity. And if the Clinic, endowed with authority, takes the responsibility of lowering and loosening the rigid claims, these mothers will usually be quite willing to compromise. Their sensitive super-ego responds immediately to the demands of the Clinic. Fred's mother, soon after her contact with the Clinic, encouraged Fred to fight in open battles with his enemies, which proved to be

a release for his repressed hostility. She declared herself willing to take all responsibility for his torn and dirty clothes. Ellen's mother received great reassurance from her contact with the Clinic, the tension at home was released. Ellen was given more freedom, the mother ceased pushing her in her school work, social activities were provided, and she joined a girls' club. When the mother's claims could be reduced, her anxiety that the child would repeat her own failure, could be decreased. Still the Clinic could not re-build her life pattern and could not be expected to change her into a warm and motherly woman.

3. REJECTING MOTHERS

The detrimental results of early frustration in childhood are being more and more recognized. The earlier a frustration occurs, the weaker the ego which has to cope with it and the more damaging the consequences. Food, shelter and warmth are not the only needs of the young child which must be met. His craving for affection plays as important a part in his growing up as the factors mentioned above. The first person to satisfy the child's longing and to provide for his comfort is his mother. If she handles him too roughly and without love, a deep disturbance in the child's basic security will result. The baby who feels the mother as part of himself is, as a consequence, damaged in a part of himself. His early narcissism as well as his later capacity for love and identification are reduced when a predominantly negative, instead of a positive, mother relationship exists. The process of growth is intimately bound up with gratifications. Frustrations resulting from early rejection by the mother bear directly on the development and affect the biological growth of the child. A mother may be called rejecting if her "behavior towards the child is such, that she consciously or unconsciously has a desire to be free

from the child and consider the child a burden."[11]

M. Ribble, in her "Clinical Studies of Instinctive Relations in New Born Babies," points out that an infant, after an early frustration, "seems to be sensitized to situations of disappointment and a tendency to function according to an earlier pattern is instituted."[12] A. Kardiner[13] also emphasizes that even the powerful nursing instinct may collapse if the nursing fails at the very beginning and results into a frustration often due to mother's rude and impatient handling which results from rejection. It is probably true that more children starve from lack of affection than from lack of food.

On the other hand, seen from the angle of the mother, the wish for and the love to the child is the very expression of accepting womanhood. The child represents the solution of how to accept the reality of being a woman. A mother who rejects her child expresses thereby the denial of the role of her sex. It will not be surprising to find that she demonstrates the same resentment of her womanhood by other symptoms, such as hostility against the envied men in general and her husband in particular, and by

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11 M. Figge, "Some Factors in the Etiology of Maternal Rejections," Smith College Studies in Social Work, P.242

12 M. Ribble, "Clinical Studies of Instinctive Reactions in New Born Babies," American Journal of Psychiatry, July, 1938.

13 A. Kardiner, "The Role of Economic Security in the Adaption of the Individual," The Family, 17:190, October, 1936.

frigidity in the blocking of sexual activity. Her inability to accomplish the normal feminine development may be due to her own unsolved childhood problems. We will therefore expect to find a great deal of marital difficulty in many cases of rejection. Figge,[14] in a study of thirty-five rejecting mothers, found sexual incompatibilities in 66%--twenty-five out of thirty-five cases. Two cases from the child guidance clinic may serve as illustrations.

Case of Joan K:

Joan K., three years and nine months old, was referred to the clinic because of her aggressiveness and destructiveness. She attacks her ten months old sister with a knife, is unmanageable by the mother, damages the furniture, has temper tantrums, refuses to obey and to eat. A symptom especially unbearable for the family is her night terror. Every night the child gets up from bed, comes to the parents' bedroom with all signs of terrible anxiety and insists upon sharing her mother's bed. The father must get up and give his place to Joan and sleep on her couch for the rest of the night.

Mother had a severe melancholia during pregnancy and did not want the child. Birth was normal, but the child started to be a problem from the first day. She cried day

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14 Figge, op. cit.

and night, was restless and did not sleep at night, and did not want to take her formula (her mother could not and did not want to nurse her), and was always constipated. The early developmental history was normal. The child had always been a feeding problem, refused to eat unless bribed by the mother with toys, and she still drinks milk from the bottle. Joan had always been a very poor sleeper and displayed temper tantrums as long as mother can remember. When mother put her to bed she cried for an hour and the mother would finally have to take her up.

An I.Q. in the range of normal (about 90) was obtained. The child is an attractive, pretty little girl, but is very dirty, poorly cared for, her hair is unkempt. Her face has a strange, old expression. The mother still must dress her as Joan refuses to do it herself.

Since the sister has been born, her behavior has grown progressively worse. The mother likes the second child and stresses continuously in the presence of Joan how good that child is while Joan makes her unhappy, and that she would be glad to be rid of her. Joan responds with temper tantrums, throws things at the mother, and hits the baby. Once she took a knife, threatened to hurt the baby, and finally hurt herself over the eye. The mother punishes her severely.

Joan was always afraid of the dark. Mother has to sit by her bed until she falls asleep. Since the birth of

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her sister her anxiety has increased. Joan slept in the parents' room before the baby was born.

The Mother: The family, orthodox Jewish, lives with maternal grandparents and maternal aunt. Maternal grandparents came from Lithuania to U.S. when mother was sixteen. In the first World War their village was alternately taken by the Germans and Russians, maternal grandmother was captured by the Germans and was unable to return home for six months. The family lived in England before coming to U.S. and grandmother was in a hospital for mental diseases there while the children stayed with relatives. Mother is the second oldest of five siblings. She cannot remember having had any pleasure in life at any time. She finally married the father, with whom she was not in love, because she felt secure with him and "could trust him." After marriage she refused intercourse for three months; finally she forced herself because she thought "she had to do it," but she never enjoyed it and was always frigid. She uses the Jewish regulations of sex life as an excuse to deny intercourse to her husband. In pregnancy with Joan she developed a melancholia, suffered from depression, and felt life was senseless. She was treated by a competent psychotherapist but without result. The mother blames her husband because he is "too easy," accepts everything and never forced her to have intercourse. She thinks that force would have been

better. She has no sexual relations with him now. She has deep contempt for him because he was never able to make enough money for their living expenses. Money has an enormous emotional value for her. Mother argues with him and with maternal grandmother repeatedly. She refuses to go out with him when he asks her. She cannot stop talking, nagging and worrying. Sometimes she thinks she would like him to take Joan and go away with her. She does not give birthday presents to Joan or arrange for other pleasures for her.

The father is of Russian stock. He came to America when he was 18 years of age, but has not been naturalized. He works in a shoe factory. He is quiet, easy going, and affectionate, submitting to all trouble with a passive, patient attitude. He is fond of Joan, likes to spend his money on her and buys something for her "as soon as he has one nickel." Joan loves him, wants to be kissed before he leaves, and is very demonstrative. Father tries to excuse Joan and to minimize the gravity of her symptoms.

Here we are dealing with a clear case of early rejection and the deplorable consequences it had on the child. Mother who has not solved her own infantile problems is not able to accept her role as a wife and mother. She is apparently suffering from a masculine protest and she resents the functions and duties of a wife, and she feels

they are a disgrace. She refused to accept her sexual role in marriage for three months, and, when she forced herself to do it because her mother told her it was her duty, she was not only unable to enjoy this manifestation of her being a woman, but she directed her whole aggression and hatred against herself and punished herself in her melancholia for having submitted to the fulfillment of her sex in bearing a child. After the birth, she directed her aggression against the child. She could not but look upon that first child as upon the incarnation of her defeat and one of her favored phantasies which she likes to discuss is that Joan was not her child but that hers had been changed in the hospital. Joan was deprived of early tenderness and security and reacted with all means at her disposal, with nervous restlessness and symptoms of frustration. The biological functions such as sleep and hunger were affected. The child fixed her mother's attention on herself by refusing to eat, thus keeping mother busy feeding her and therefore punishing her for her rejection at the same time. Her constipation and her stubbornness were part of the same pattern of punishing the mother. She solved neither the problems of the oral nor the anal phase properly. The mother, on the other hand, was bound by her guilt feelings to keep Joan dependent. She fed her, dressed her, and took her in her bed. The home atmosphere of repressed aggression

of the mother against the father and the maternal grandmother as well as the birth of the little sister increased Joan's difficulties. Her death wishes against her young sister are evident, and when she hurts herself with the knife instead of the baby, it means at the same time a punishment for herself and for her mother. Her great anxiety at night proceeds from the fear "that the death wish against the mother and the sister might be masochistically realized on the own person."[15] She finds release from that anxiety only in mother's bed, in the presence of the simultaneously loved and hated love-object. In addition to this satisfaction, her anxiety serves the purpose of separating her father from her mother, as it fulfills her libidinal wish to be close to the mother.

Another case illustrating the results of mother's rejecting attitude is the Case of William M.

William M., six years and four months old was referred to the Clinic for enuresis. There is a long list of other problems such as thumbsucking, poor appetite, restlessness, disobedience and speech defect. He is a delicate, nervous little boy who never seems at ease. In spite of his high average intelligence (I.Q. 107), he has difficulties

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15 H. Deutsch, Psychoanalysis of the Neuroses (London: Hogarth Press, 1932), p. 102.

with his school work because of his disability to concentrate. He is considered immature for his age. In his attitude toward his mother, William is "fresh," disobedient, uses obscene language, and is absolutely unmanageable. He is stubborn and aggressive, depends on mother who dresses and feeds him, and has constant need for attention. When mother strikes him in her efforts at discipline, he strikes back.

William was of a normal full term birth. He was never breast fed and had feeding difficulties from the beginning. He always appeared hyper-active, did not learn bladder control, was enuretic at school and occasionally at night.

The Mother: The mother is an irritable, tearful, unhappy person. She has a diagnosed thyroid condition of psychogenic origin. She constantly worries and has no outside interests. She does not mix well with the neighbors. Her only interest seems to be William. She babies him, trying to make herself necessary to him as long as possible. She is unstable and full of anxiety, running from hospital to hospital for reassurance as to William's health. She nags him frequently and interrupts his play. She discusses her disability to handle him. She is discontented and always preoccupied with her own affairs. Not much is known about this mother's childhood. She married the father without love because she thought "it was the thing to do," and because she hoped he would always be able to support her,

since he was a college graduate. She expected him to get a good position and thought she was "set for life." She was deceived in that respect, however, for he did not find steady employment and is on the W.P.A. now, earning $16 a week. The father and mother quarrel constantly. The father was an only child and was adopted by his paternal grandparents. The paternal grandmother did not want to "give him up in marriage." The grandmother did not approve of their marriage and wants to have nothing to do with the mother. The mother is sexually frigid and stated spontaneously that they have had no intercourse for over two years. The father is always out playing bridge, sometimes the whole night through. She describes him as an "extremely peculiar and maladjusted person." He is "limited, supercilious and opinionated" and has no interest in the mother or their child.

This mother also is a childish, neurotic person who did not grow up to adulthood. She did not accept her role as a woman, was never able to enjoy love and motherhood, had no affection for the man she married, and no genuine love for the child she bore.

Both Joan's and William's mothers show great similarities as far as the etiology of their rejection of the child is concerned. Both suffer from their own unsolved

infantile problems, which block their further growth. Neither has been able to accept the reality of being "only a woman," and both express their unconscious resentment in frigidity, aggression, and hatred directed against the husband. Both chose husbands who are not of a very masculine type, and they both reject the child who represents the very essence of their sex function. Both mothers are unhappy, idscontented women, withdrawing from outside interests and social contacts, becoming increasingly preoccupied with their worries. So far the same dynamic forces can be seen at work. But from there on, they work out their needs in different ways.

Joan's mother rejects the child openly and misses no opportunity to verbalize her aggression, using various defenses to keep her guilt feelings in check. She imagines Joan is not her real child and, paradoxical as it may sound, she needs the child's misbehavior as a justification and excuse for her rejection.

William's mother, on the other hand, never expressed open rejection. Her resentment is covered up by a reaction formation of over-protectiveness and over-solicitude. She goes from one hospital to another with her boy, full of anxiety that her unconscious resentment may have hurt him. She babies him and makes herself necessary to him. Her attitude towards him is permeated with anxiety and guilt

feelings. Her aggression finds expression in nagging and scolding and denying him freedom of movement. Levy has called attention to the phenomenon of over-protection in its meaning as disguised aggression.[16] Rosenheim, in his article on parents' attitudes as observed in child guidance clinics, pays tribute to these factors which are "found to play an important role in the problems which come to light at the clinic."[17]

Treatment Implications: The rejecting attitude is not only the one which causes the severest damage to a child, but also it represents the greatest difficulty and least accessible problem for the clinic and the social worker. Reaching far back and deeply rooted in the mother's repressed childhood conflicts, it can hardly be influenced by environmental manipulations and reassurance. Advice and superficial change in the mother's tactics are of little importance as long as the fundamental underlying attitude remains unchanged. This, in its turn, is unconscious to a great part and, if touched upon with the mother, causes much anxiety to be aroused, and a strong defense is likely to be built up. Psychotherapy or analysis which enables the mother to understand herself and to realize the mech-

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16 D. Levy, "Maternal Overprotection," Psychiatry, 2:753, 1939.

17 F. Rosenheim, "Parental Attitudes as Observed in Child Guidance Clinics," Psychiatric Quarterly, 9:279-286, April, 1935.

anism by which she projects her aggression on to the child, would be the only way to re-make her into a healthy person, capable of giving and accepting love. This, however, transgresses the possibilities of a child guidance clinic, where the child is considered the patient in the first place. Lack of time, money, and understanding would, in most cases, be a barrier against treatment of that sort. Therefore, the second best has to be done--i.e., the social worker must try to establish so positive a relationship with the mother that the inner tension can be somewhat released and the mother may gradually realize that she has a part in what is going on. These mothers are starved for sympathy and social contact, and will probably be responsive to the social worker's attempt to establish some degree of transference. With Joan's mother, it took months before she was capable of accepting the fact that Joan was doing well in the nursery school for which the clinic had arranged. Then Joan's mother began suddenly to realize that she herself was a factor also, and shifted the responsibility immediately to the social situation, the financial strain, and the congested household. She was scarcely able to agree to a camp placement for Joan for fear that "something might happen to her"--i.e., afraid that her unconscious wish to get rid of the child might be fulfilled as a punishment. William's mother received much comfort from the clinic's sharing of

her responsibility. It was recognized that it would have been of great help in both cases if some satisfactory employment could have been arranged. Working outside the home and making money, which is felt to be a masculine privilege, would have given gratification and comfort to these mothers--but it was impossible at the time.

4. Overconcerned Mothers

It has been pointed out in the previous chapter that the primary dependency of the child on the mother is a biological need determined by the child's helplessness. This need may be frustrated, as in the case of rejection, or it may be prolonged beyond its normal function. Such frustrations and prolongations are partly the result of the attitude of the mother toward the child and partly the result of the attitude of the child toward the mother. The second alternative, prolongation of the dependency attitude, is briefly discussed in the following paragraphs.

From the point of view of the child, analysis made the discovery that children do not perceive their helplessness but, on the contrary, they feel as if they controlled the world in a magical way. Their control over their environment is exerted through the mother's agency which satisfies their needs. But this period of "magic omnipotence" does not last long. "When the techniques of magic control begin to fail, the environment and the process of growth stimulate new forms of adaptation in the individual."[1] New types of mastery and new types of gratifications are found

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1 A. Kardiner, The Individual and His Society, New York: Columbia Press, 1939, p. 33.

and a feeling of confidence in them is established. If the guardian for some reason continues to hold the child close to her and continues the "magic service," the child in its turn will fail to use new resources, will continue to expect outside help, continue to use a technique of retreat, and an attitude of dependency is established. This ego attitude of dependency, however, has undergone a change. In infancy, "we assume that the child has endowed himself with an attitude of omnipotence. But in the attitude of dependency he endows his parents with this magical attribute."[2] The child's attitude, therefore, is accompanied by a recognition of his limitations and by a diminution of his self esteem, and has disastrous effects on the effectiveness and independency of the individual. Failing to develop new techniques of mastery and to derive the necessary satisfaction from them, he may react with aggression, with anxiety, or with inhibitions.

From the point of view of the mother, there may be various reasons why she needs to continue to make herself necessary to the child and to keep him dependent on her. In Ellen's, as well as in William's, case, the mothers transformed their original rejection and aggression into over-protectiveness and over-solicitude, with the result of interfering with the child's development. Two other

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2 Kardiner, op. cit., p. 33.

unconscious motives for over-concern will be illustrated in the next two cases.

Case of Paul W.

Paul W., a boy of 6 years, was referred to the clinic because of enuresis nocturna, tics, night terrors, food capriciousness, and poor social adjustment. He is a delicate little boy, twitching his body and shrugging his shoulders and picking at his nails and fingers constantly. He is restless, capricious about his food, and wakeful at night, at which time he calls his mother. When he entered kindergarten he did not know how to play with children. He whines and cries if he does not get his own way. Paul has always had a great deal of attention from adults and has always been the center of the stage. He is a great "performer"--sings, dances, and wants constant attention. He is jealous if there is any other child in the house. If the mother picks up another child, he wants her to put him down immediately.

He was a full time normal birth. He was not breast fed. He was always a nutritional problem, and it was difficult to find a formula for him. The mother used to fuss with him continually. She has spent a great deal of time on his food, cutting vegetables into different designs and pleading with him to eat a little bit. He relied entirely

on the mother for dressing him until he was five years of age, and he was never dry at night.

The Mother: The mother is receiving aid for dependent children since she has been separated from the father for some time. She is still fond of the father and "would like to live with him later," but she started legal separation because he was alcoholic, and struck her, and she was afraid for herself and the boy. The mother is irritable and excitable and worries a great deal. She and Paul live alone. She centers all her interest, affection and consideration on him and keeps him emotionally close to her. The boy, however, sleeps in his own room. She reads Parents' Magazine and pamphlets and is very anxious to train him wisely. She is overly conscientious, anxious about his care. He was never allowed to play outdoors or to do anything unsupervised. The mother is anxious, too, about his physical health. She fears that he might become ill if he does not eat as much as she feels he should. Sometimes she does not allow him to go to kindergarten, because she is afraid he might get a cold or a disease. There was never any discipline in the home. Paul does what he pleases and his mother ignores his misbehavior.

The mother had an unhappy child. The maternal grandfather deserted the family when the mother was three years old. The maternal grandmother died soon afterwards and mother

was placed in a home for destitute children and later in a foster home. The foster parents liked her and she was treated as their daughter. Mother graduated from high school, is moderately intelligent, and is a warm, affectionate person.

This mother, in contrast to the rejecting mothers, concentrates all her attention and love on her boy, and there is too much concern about him since the father left the home. The mother is possessed by constant anxiety lest she lose him as she has lost her father, her mother, and her husband. In her over-solicitude to keep what is left to her, she indulges him, makes him the center of the stage, and increases his need for constant attention, simultaneously keeping him dependent by impairing his confidence in himself and his techniques of mastery. Her nervous anxiety is centered around him and her constant supervision and control seem to make him self-conscious and afraid, increasing the tension and insecurity in the fatherless home. The mother, lacking any other love object, loves him in an exaggerated way, at the same time keeping him away from experiences and activities which might stimulate his self-confidence. The illusion of "safety through dependence" continues, and the mother, without being aware of her possessiveness, aims at keeping the boy her own by making him cling to her. The more this tendency remains dominant,

the more attention he needs, and the less incentive he has to outgrow infantile attitudes which may be used as attention-getting mechanisms.

Another example of an over-considerate mother is found in the Case of Dora V.

Dora V., eight years old, is a girl of superior intelligence (I.Q. 123) referred to the Clinic because of a loss of interest in school. Her mother seemed utterly disturbed about the fact that her daughter had only two stars for effort in school while duller children received more. She suggested that Dora should be ashamed of herself, but as a matter of fact, she was not. Dora is a shy little girl, very small for her age. She is babyishly dressed up and looks pretentious in her bonnet with ostrich plumes, while the mother, although neatly dressed, gives the impression of not caring about her personal appearance. Dora's attitude is one of great emotional insecurity, as she bursts into tears when asked to go to the examiner's room. In her test she is apprehensive, thoughtful, and accurate, but lacks spontaneity. She is self-centered and mother-dependent. She shows little interest in food, sucks her thumb at night, and is stubborn and seclusive. It takes her a long time to fall asleep. She wakes up at night, calls to her mother, and wants to share her bed. She is very jeal-

ous of her father, prefers the mother, and does not like her to leave her. She is given to much day-dreaming at school.

Dora is an only and much wanted child. The mother knows she can have no more children. Dora's birth and early development were normal. She was breast fed for eight months. The child is the mother's one great interest and only concern in life. Much attention was paid to everything she did. Dora always liked to be with adults and children older than herself. Her play activities are inadequate. There is a play yard not far from her house, but Dora has never been there because the mother likes to be able to see her all the time she is playing. The child has no friends or outside interests. The mother has given her no sex information.

The mother is concerned about Dora's lack of interest in school--in fact, more than about all her other problems. She thinks the child should be in a higher grade and asked the Clinic to arrange with the school for a double promotion. The mother is extremely critical of the school situation, feels more attention is given in school to other children because they are backward. She comments, "It is not their fault that they are not bright. Their parents do not devote enough time to them. They play bridge, go to the movies, and send the children to school only to have them

out of the way." The mother feels that Dora should not have to associate with such children, and thinks of sending her to a private school. She would like to have her take either dancing or dramatic lessons. She does not want her to come home after school and read and play and do nothing else. Dora, questioned about it, said she does not play outside after school but sits at home sewing with her mother. The family lives in a well-furnished, middle-class home in a good neighborhood. The mother does not like the neighbors and feels superior to them. The father is a steamfitter and the mother augments the income by sewing. He is not sociable and seldom leaves their home. The mother describes him as being high-strung, likely to lose his temper and speak sharply.

The mother is one of ten siblings and still sees the maternal grandparents daily. She was always bright and excelled in school but found it boring since she did not have enough to do. The mother says Dora, in this respect, is just like her. After school she was trained to be a dressmaker, but most of her siblings were much more highly educated. The mother is anemic, has low blood pressure, and feels worn out, although she is only thirty-six years of age. She has given up having friends come in for the evening since she feels that they keep Dora awake. She is inclined to take things seriously and to be overly conscientious. She is always

worrying about Dora--that she is too thin, too frail, that she goes to bed too late, and has too little sleep. She would like to have a physical and mental examination for her every week. She is extremely anxious to discuss the child in detail and to present her in a very favorable light, but becomes very angry if the Clinic does not agree with her in all points, and disapproves of letting the child skip one grade.

In this case, the child's difficulties are also caused by the mother's over-solicitude, as illustrated by her denying Dora all independence. This mother, too, is a tense, emotional person, concentrating all her thoughts on Dora, who is her only interest in life. Her marital relationship is not very satisfactory. The child reacts upon the constant pressure of being pushed ahead by withdrawing into day-dreaming. She escapes the unpleasant reality situation by reading and by resorting to her phantasy life for satisfaction, and is developing into a shy, sensitive, seclusive, introverted person.

Fostering the child and her problems fills some need in this mother's life, as in the case of Paul's mother. But in contrast to Paul's mother, who looks upon the child as the only love object which she wants to possess, this mother has an over-identification with her daughter, considers her a part of herself, and expects her to solve her

mother's own problems. She hopes she will fulfill all the mother's ambitions and succeed where she has failed. Her ambitions for Dora probably rise from her own feelings that she is less educated than her siblings. Dora must compensate to her for this. The mother's life is barren; she has resigned herself to martyrdom for her child, and has renounced the pursuit of her own goals and pleasures to seek them in her child. Superficially it would seem as if she were living for her child's good only. The opposite is true. Unconsciously, and by means of identification with the child, she expects to fulfill her own wishes and to accomplish the achievements she has missed, through her child.

Treatment Implications: These over-concerned mothers are the greatest concern of the Clinic. Whatever the Clinic does is not enough. They not only expect the whole personnel of the Clinic to be openly sympathetic with their children, but they are not satisfied with the service offered unless the Clinic shares their over-solicitude. Paul's mother felt much relieved in talking the situation over, in having the Clinic release her anxiety. Arrangements for the boy were made, and though many of the symptoms such as enuresis and night terrors have disappeared and Paul now enjoys going to kindergarten and to a boy's club, the mother still complains that more should be done, and

presents a new request every week.

Dora's mother is very critical of the Clinic's service and rather disappointed in it because there is too much negation of what she insists should be done. She wants the Clinic to arrange for a change in school and asks for new tests and examinations every week. The teachers and principal in the school are exasperated with her. She has pre-conceived ideas of what should be done. All that does not fit in with her plans results in opposition and resentment. She is determined to make her child a prodigy and is not able to accept the Clinic's disapproval of a double promotion, extra lessons, and the suggestion of giving a more adequate play and social life to her timid little girl. This mother, in her dissatisfaction, has recently appealed to another agency and has been referred back as "unable to accept help, since all suggestions fall on deaf ears."

These mothers are omnipresent and indulge in endless discussions and complaints, and they turn from one agency to another, disappointed and dissatisfied. It is the social worker's task to establish so positive a relationship that the rejection of their claims becomes tolerable and they finally are able to see the child with the worker's eyes and from the Clinic's point of view.

CHAPTER IV

SUMMARY AND CONCLUSIONS

This study has attempted to present a cross-section of cases studied at a child guidance clinic and some of the most characteristic attitudes of mothers coming to the clinic. The selection of cases has been made exclusively with regard to the mother's problem, and the cases have been discussed only insofar as they are influenced by the mother's attitude. Other factors of equal importance, such as the father relationship, sibling rivalry, sex curiosity, and many traumata and anxieties involved, have not been dealt with, since it was not intended to discuss the dynamics of the cases as such, but only to call attention to some typical maternal attitudes, as causative factors, which are met frequently at a child guidance clinic. It has been shown that in the so-called "normal" and healthy mother-child relationship many factors are present in nuclei, which create conflicts and ambivalent feelings. If these factors are out of balance, clinical cases are the result.

Eight cases have been presented--two cases of each type. The orientation of the mother within the id-ego - super-

ego system, on one hand, and the early relationships on the other, served as frame of reference and principles of classification.

This discussion has dealt with the mothers with the weak ego and super-ego, two of each type--one who accepts the child and the other who does not. Further, two cases of rejection, one open and one disguised, and two cases of over-concern and over-solicitude, one caused by too much stress on one love object, the other by over-identification for the purpose of substitute gratification, have been presented.

These clinic mothers have been described with their anxieties and defenses which the Clinic does not dare to attack before it is able to replace them in a constructive way. The discussion has emphasized the particular adjustment difficulties to the Clinic which the different types of mothers have with regard to their own problems.

The question has often been raised whether or not a problem-to-problem correlation exists between the parents' and the children's problems. From this study this question can be definitely answered in the negative. Once more it has indicated that the total situation affects the whole person always, as outlined by the Gestalt theory. The single factors overlap each other, and cause and effect cannot be correlated in a mathematical ratio. It is cer-

tainly wrong, for example, to assume that rejection in the parent will always be followed by food problems in the child, as in the case of Joan. It appears to be related to the staling, in the case of Mary, and to enuresis in William's case. On the other hand, it looks as if Paul's food capriciousness is connected with the mother's over-solicitude and spoiling attitude. The same symptom may have different meanings in different cases, and different symptoms may have the same meaning.

A point to point relation cannot be established and the sequences cannot be figured out a priori, nor can predictions be made with any degree of certainty. The question of the choice of neurosis and symptom formation is still an unsolved problem, though certain reaction type patterns may be recognized. The concepts of "rejection" and "dependency" are based on the insight into certain dynamic processes, but the combinations of factors involved change in the individual case. In an investigation which has been made on the relationships between the problems of habit clinic patients and their parents it has also been shown that there is no strict "problem to problem relationship between the problems of parents and their children and that the factor of personality cannot be isolated from all the other factors found in a total parent-child situation."[1]

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1 A Berk, M. Tandy, L. Lane, "A Study of the Relationships between the Problems of Habit Clinic Patients and their Parents," Bulletin of the Massachusetts Department of Mental Disease, 17:61, April, 1933.

It is true that "in the child's life the parents' personality, especially that of the mother, colors all the environmental factors,"[2] which corresponds closely with the parents' personality adjustment.

In trying to understand the fundamental personality make-up of the mother it is necessary to go back to her own childhood experiences and to see her in her parental setting. So the vicious circle is closed--causes bring forth effects and effects are new causative factors in their turn, and so on ad infinitum. It has been shown that six of the eight mothers of this study had extremely unhappy childhoods and lost one of their parents at an early age either through death, desertion and separation. The child guidance clinic, in every case, is confronted with a definite reality situation of the present, and its task is to disrupt the vicious circle by breaking it up at some point. It is a question of technique, whether it is done through the child or through the mother or through both. The assumption is that the whole will be changed if a part has been, and that the whole system will be affected from whatever part the attack is begun. On the other hand, the fact must be kept in mind that it is never the single symptom in itself which matters, but the basic attitude behind it. Nothing is achieved if one symptom disappears, only to be replaced by another one, or if a mother changes a single means of

2 Ibid., P.61

treating the child without changing the emotional attitude expressed by it.

The mothers coming to the Clinic for help are overwhelmed with anxiety and guilt feelings. If the social worker, repeating her own unsolved conflicts with her parents, identifies with the child against the mother, the latter will be forced to fortify her defenses against both the worker and the child, and little will be accomplished, for the energy will merely be wasted in the struggle. There is only one valid basis of a treatment relationship --the identification of the worker with the mother. But it is not helpful to identify with the mother's pleasure drives, which may be a temptation, especially with delinquent mothers under certain conditions, nor with the mother's exorbitant claims and super-ego demands. The ego is the basis for the social worker's approach. The task is to strength the ego in its trifold function as compromising between id, super-ego and reality. There is no need for the worker's personal approval or disapproval of an attitude. Insight into the process involved takes its place. However, to understand a situation is one thing, and to make the mother understand it is another entirely different task. Rational interpretation will do no good as long as the mother is not ready emotionally to accept that interpretation. It will only strengthen

her defense. Therefore it has been emphasized by many authors that it is the relationship which really matters in the social work process, and which leads to effective treatment. The content of that relationship may be expressed in the mother's feeling that the worker will stand by her as a friend and will understand her, no matter whether she is right or wrong. In the state of increased security and reassurance created by this relationship, and with rising emotional energy which always results from any kind of transference, the mother may be able to accept the interpretation hinted at by the worker as her own interpretation, and to use it in a productive way. By this method two persons, the mother and the child, receive guidance and relief, and social work has achieved something more than an evanescent assistance; it has helped to destroy roots of unhappiness and has improved the conditions of the community.

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